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Independent Regulatory Review Commission

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To the members of the Internal Regulation Review Committee:

Sarah A. Reed Children's Center in Erie, Pennsylvania specializes in mental and behavioral health care for children, teens, families and individuals. We specialize in trauma-informed care by providing innovative evidence-based treatment and services through research, clinical practice and professional training. We offer a full continuum of care including Psychiatric Residential Treatment, Partial Hospitalization, Outpatient, and Intensive Behavioral Health Services. We serve a diverse population of approximately 1,700 individuals annually from 46 counties throughout Pennsylvania.

Please accept Sarah A. Reed's Children's Center's comments on the proposed §1330 and §5330 regarding the payment of the psychiatric residential treatment facilities and the minimum licensing requirements, respectively. Sarah Reed applauds OMHSAS's efforts to ensure that children, adolescents, and young adults receive excellent behavioral health treatment. However, we are concerned that the promulgation of these regulations would have grave negative effects.

First, the minimum treatment standards in the regulations require a dramatic increase in the amount of psychiatric and clinical time that the PRTFs would need to supply. PRTFs would face two onerous barriers: The national shortage of psychiatrists, mental health professionals, and nurses and inadequate MA funding. The additional clinicians needed to satisfy these proposed rules are not available and, even if they were, PRTFs are not adequately funded to hire them. Promulgating these rules will inevitably result in further loss of bed capacity and hurt Pennsylvanians needing this level of care.

Secondly, the proposed regulations multiply administrative and training burdens without improving client care. The rules halve the time allowed to complete reportables. The required documentation following manual restraints increases exponentially while the available reporting window, in some cases, drops from 24 hours to one. Indirect staff, such as billers or maintenance staff, will be assigned an additional 30 hours of annual training including topics irrelevant to their work. These are just a sample of the additional requirements that will add further stress to already over-taxed systems without providing discernable benefit to the clients.

Moreover, the proposed regulations were developed without adequate provider input. The last provider consultation occurred in June 2020, and the final draft includes several rules that PRTFs were not afforded the opportunity to review or comment on.

Additionally, OMHSAS's estimated fiscal impact on providers makes two unrealistic assumptions:

1. **Full Staffing:** OMHSAS assumes that PRTFs are fully staffed, despite ongoing workforce shortages. This assumption is untenable and disregards the significant challenges providers face in recruiting and retaining qualified personnel.
2. **MA Enrollment:** The agency's report to the IRRC assumes that Medicaid Advantage (MA) plans will absorb additional regulatory costs, even though MA enrollment in Pennsylvania has declined. This projection is unfounded and fails to consider the current landscape of MA coverage.

To ensure the viability of PRTFs and the quality of services provided, these regulations should not be implemented until PRTFs can submit detailed fiscal impact statements and realistic financial modeling is conducted.

Respectfully submitted,

Larry Shallenberger

Associate Vice President of Compliance
Sarah A. Reed Children's Center

Comments Regarding the Proposed §1300 and §5330 Regulations

by Sarah A. Reed Children's Center

§1330.30 Nonallowable Costs (a)(7): Costs for a service if payment is available from another public agency, insurance or health program or any other source.

Separating program expenses by clients who are MA versus those covered by other payors creates an administrative burden.

§1330.30 Nonallowable Costs (a)(9)(iii) Staff recognition, such as gifts, awards or dinners. (iv)

Employee reward and retention strategies such as gift cards, recognition breakfasts, T-shirts, bonuses, the employee picnic, sports teams, and referral awards would no longer be allowable in the cost report. These strategies are valuable to show appreciation to the PRTF employees, contribute to a sense of teamwork, and aid with retention.

§1330.30 Nonallowable Costs (a)(9)(ix) Meals for visitors.

This agency hosts parent engagement weekends twice a year in which we educate them in the Sanctuary Trauma-informed model. We also host a Thanksgiving Dinner to promote family engagement. This proposed rule would make it difficult to continue these practices.

§1330.30 Nonallowable Costs (a)(9)(xviii) and (xxiv): Client hygiene items and clothing are nonallowable costs.

When parents and guardians are unable to adequately clothe their clients, this agency absorbs the cost of clothing without reimbursement. Under the new proposed regulations (§5330.31) clean and seasonal clothing are not categorized as a client right, placing the burden of purchasing these items on the PRTFs without providing appropriate reimbursement.

§1330.30 Nonallowable Costs (a)(9)(xxiv) Transportation and living costs associated with onsite visits by parents, legal guardians or caregivers.

The agency currently provides parents with gas cards and hotel rooms to help economically challenged parents who live a distance from the PRTF visit their children. There is an obvious benefit to the client through the strengthening of the parent-child bond. Disallowing this expense will make it difficult for the agency to continue this practice.

Alternate Rule: Establish MATP reimbursement for parents traveling to medically necessary visitation and therapy in a PRTF. Or allow providers to account for this cost.

§1330.31 General Payment (b) The MA Program will pay for medically necessary services provided to a child, youth or young adult who is an MA recipient by a residential treatment facility licensed under Chapter 3800 and certified by the

Department as of [*effective date of final-form rulemaking*] for 12 months after [*the effective date of this final-form rulemaking*].

This proposed rule starts the countdown to an inevitable licensing crisis among providers. Requiring PRTFS to acquire extra psychiatric, clinical, and nursing hours against the setting of a well-documented national shortage of these providers while providing no realistic assurance of adequate remuneration is confrontational and endangering to behavioral health providers.

This agency fails to appreciate the urgency to promulgate and enforce these regulations without OMSHAS consulting with PRTFs and the Behavioral Health Managed Care Organizations to ensure the financial viability of the model. The agency requests that the IRRC call for this collaboration to occur before considering promulgating these regulations.

§1330.32 (a)3 MA will pay a PRTF if the following conditions are met: The independent team is independent of the psychiatrist who completed the psychiatric evaluation and the PRTF that is being recommended.

This agency cautions that the demand Minimum Treatment Standards Section of the 5300s pleases on PRTFs for increased psychiatric hours will potentially make it difficult to acquire an independent evaluation for the client due to many psychiatrists in rural areas serving dual roles. PRTFs often share psychiatric resources with outpatient clinics and partial hospitalization programs. This is but one example of how increasing the demand for psychiatric hours in the behavioral health system will result in restricting clients' access to needed services.

§ 1330.33. Limitations on payment. (a) MA will pay for hospital-reserved bed days for a PRTF that is currently participating in MA as follows: (2) Payment for hospital-reserved bed days is limited to 15 cumulative days per calendar year, for each child, youth or young adult, regardless of whether the child, youth or young adult was in continuous or intermittent treatment at one or more PRTFs during the calendar year.

This rule will force PRTFs to be more cautious when considering admitting clients who have already accumulated a significant amount of hospital bed days in the calendar year. This has the potential to limit access to clients most in need access to PRTF treatment.

The agency recommends that this rule be omitted.

§ 1330.33. Limitations on payment. (d) MA will not pay a PRTF for the following: (1) A day of care during which a child, youth or young adult was absent from the PRTF for one of the following reasons: (iv) Visits, unless the visit meets the criteria in subsection (c).

The agency seeks clarification on whether this rule applies to prescribed therapeutic leaves. If so, the rule creates a barrier to necessary part of the discharge process.

§ 1330.39. Annual cost reporting and independent audit. (a) Residential treatment facilities that are licensed under Chapter 3800 and certified by the Department [*as of the publication date of the final-form rulemaking]* shall provide a projected cost report to the Department within 3 months of [*the publication date of the final-form rulemaking*].

Asking the PRTFs for cost reports three months after the promulgation of these regulations is akin to beginning construction on a mansion before setting a budget for the project. Again, the agency requests that the IRRC require a collaborative exploration of the financial implications of regulations between OMHSAS, the PRTFs and the MCOs prior to considering the passage of these regulations.

§ 1330.40. Rate setting.

BHMCO and MA rate setting are not applied together or regulated together. The process described below occurs without acquiring the BHMCOs agreement on payment. The rule needs to account for how PRTFs will be reimbursed when there is a difference in rate.

§ 5330.13 (c) Abuse. A PRTF shall comply with the Adult Protective Services Act (35 P.S. §§ 10210.101—10210.704).

This requirement creates an extra administrative and training burden as staff will need an additional half-hour of Mandated Reporter Training annually.

§ 5330.14 (c) Reportable incidents. A PRTF shall complete an incident report through the Department's information management system within 12 hours after the following reportable incidents are known to a PRTF:

Reducing the window from completing reportable incidents from 24 hours to 12 hours creates an unreasonable burden on the residential staff who often complete multiple reportable incidents throughout a single shift. In addition to completing the incident reports in the Department's information system, staff must also complete serious incident reports regarding the same events for the clients' Behavioral Health Managed Care Organizations (BH-MCOs), as well as notifications to parents and referring agencies. The condensed deadline creates the potential for the reduced quality of documentation as staff strain to submit their documentation within the twelve-hour window. PRTFs would need to consider hiring administrative staff to ensure compliance.

It is also unclear how this requirement improves client care as there is no indication that the Department will be offering support to the provider or client in a more expedited manner.

Alternative rule: This agency proposes the §3800 regulation allowance of 24 hours to inform the Department of a reportable be maintained in the §5300 regulations.

§ 5330.14 (c)(5) Incidents of physical assault involving a child, youth, or young adult or PRTF staff.

The agency appreciates OMHSAS' intention to protect clients with this rule. However, we serve a young and impulsive clientele who often get into minor physical altercations that do not result in injury and that, at times, are developmentally normal for their age.

Reporting each of these childhood skirmishes represents an unproductive administrative burden for the front-line staff.

The agency requests that the Department provide a definition of assault that would instruct the PRTFs to report only significant acts of aggression.

§ 5330.14 (e) A PRTF shall report the following reportable incidents to the State-designated Protection and Advocacy system no later than close of business the next business day after the reportable incident is known to a PRTF.

This agency seeks clarification regarding the "State designated Protection and Advocacy system." If this is a new State Department, then providers will be duplicating the amount of required documentation after a reportable incident occurs.

Agency Request: The Department information management system (HCSIS) be configured in such a way that reportable incidents filed by providers are automatically forwarded to the information system of the State-designated Protection and Advocacy system.

§ 5330.15 (a) A PRTF shall maintain a record of the following recordable incidents: (4) Search of a child, youth or young adult or the child's, youth's or young adult's property.

The agency views this rule as a welcome safeguard of the client's right to be free from unreasonable search and seizure. In our enhanced unit, the clients are wanded every day after school to ensure that they do not smuggle contraband into the unit. The same protocol occurs after each leave of absence. In these instances, filing a recordable does not enhance client care.

We ask that the Department provide a definition of the search of a child, youth, or young person and that the definition excludes non-intrusive methods such as the use of metal detectors.

§ 5330.20 (g) A PRTF shall contact the child's, youth's or young adult's parent, legal guardian or caregiver at least once every 24 hours if a visit lasts more than 24 hours to check on the safety, health and well-being of the child, youth or young adult.

While the agency appreciates the spirit of this regulation, which provides additional support to families during therapeutic visitation, the regulation has unintended consequences. Many of these contacts would be made over the weekends by staff members who are least familiar with the parents or guardians. Moreover, the staff available to make these contacts have the potential to be ill-equipped to adequately respond to a parent or guardian experiencing distress during a visit.

It should also be remembered that the proposed regulations place other demands on the weekend staff, such as involving parents or guardians in the client restraint debriefs and the twelve-hour window for completing reportable incidents.

During the holiday season, when client visits increase, the administrative burden becomes increasingly difficult to manage.

PRTFs already account for the potential need to provide additional support for families through visit safety plans, which provide contact information for parents to reach PRTF staff or crisis services through when needed. The proposed regulation places an increased administrative burden on the PRTF without significantly improving care for families.

The agency is concerned that this regulation implies legal liability on the part of the PRTF if unsafe or harmful behavior occurs during a visit.

Alterative Rule: That the Department requires PRTFs visit safety plans include contact information allowing them to access support from the PRTF when requested by the family within 2 hours of the call.

§ 5330.31 (5) Rights. To clean and seasonal clothing that is age and gender appropriate.

The proposed regulation elevates the clients' need for clean and appropriate clothing to that of a right without providing reimbursement to the PRTF. §1300.38 (a)(9)(xviii) categorizes client clothing as nonallowable when preparing the cost report.

The Agency also requests that this regulation be reworded to “clean and seasonal clothing that is appropriate according to the client’s age and gender identity” to better reinforce the spirit of §5330.33 (Nondiscrimination).

§ 5330.31 Rights (b)(21) To have access to a telephone designated for use by children, youth, or young adults.

This proposed right needs to be complemented with PRTF’s discretion to set reasonable phone call times to ensure reasonable bedtimes, times for the provision of the required group therapy and psychosocial education, as well as staff supervision to ensure that clients are only having conversations with appropriate contacts as identified on their approved contact list.

Alternative Rule: PRTFs will be required to have a Client Phone Call Policy that will establish phone call hours, monitoring and supervision protocols, and contingencies if phone calls cannot occur during a crisis in the unit.

§ 5330.31 Rights (b)(25) To be discharged from the PRTF as soon as the child, youth, or young adult no longer needs services.

The agency agrees that clients should not be made to stay on placement longer than it is medically necessary. However, the PRTF has no control of whether a child has an appropriate discharge resource and is often dependent on outside agencies for that resource to be developed. This rule should be omitted from the client rights since PRTF should not be held accountable for the lack of resources.

Agency Recommendation: Omit this client right.

§ 5330.41. Supervision of staff.

Throughout this section of the proposed rules, it is unclear whether OMHSAS is prescribing solid or dotted lines on each PRTFs organizational charts. The agency seeks clarity on this issue.

The agency notes that this section of the rules does not support the role of the advanced practice professional in role clarity of inclusiveness. There is an opportunity for the APP to provide clinical supervision and reduce the burden of the treatment team leader.

§ 5330.41 (1) A medical director shall provide the following supervision to an RN, clinical director, or an APP.

This regulation pushes the medical director to operate outside of their scope of work. The additional time required by the Medical Director to provide supervision and observation detracts from the available time the Medical Director must serve as treatment team leader and to provide medication management.

At this agency, a licensed psychologist provides supervision to the director of nursing, an RN, who in turn provides supervision to each nurse at residential. Additionally, the Residential Clinical Director receives direct supervision from the Vice President of Clinical Service, who is a licensed psychologist.

§ 5330.41 (a)(3) A clinical director, medical director or mental health professional shall provide the following supervision to a mental health worker supervisor:

(i) Two hours of supervision each month. Of the 2 hours of supervision, 1 hour shall be face-to-face.

(ii) One hour of direct observation of the provision of services every 6 months. Each occurrence of direct observation of services shall be for at least 30 minutes.

At this agency, the mental health worker supervisors are directly supervised by the program director. The proposed regulations would consume 38 hours a month of our Clinical Director's time to provide supervision and an additional 38 hours annually of providing direct observation. This time demand detracts from the Clinical Director's proper role of establishing and training the clinical best practices of program and the supervision of the mental health professionals and case managers.

It is the position this agency that the supervision of the mental health workers remains with program director.

§ 5330.42 (a) Staff working in a PRTF shall be 21 years of age or older.

This rule will have a negative impact on PRTFs being able to develop an employee pipeline by providing clinical field experiences (practicums and internships) to students at local colleges and universities.

Alternate Rule: This agency suggests that OMSHAS allows an exception for students enrolled in clinical field work.

§ 5330.42 (c) During the PRTF's awake hours, the following requirements must be met: (2) PRTF staff providing supervision shall always be within auditory and visual range of children, youth or young adults.

This regulation is inherently unworkable. Clients have the right to privacy while changing their clothing, showering, or toileting. It is also not possible to maintain visual contact with all clients while they are in their rooms enjoying their time alone.

Alternate Rule: During the PRTF's awake hours, the following requirements must be met: (2) PRTF staff providing supervision shall always be within auditory and visual range of children, youth or young adults. If clients are in their bedrooms and visual contact with each child cannot be maintained, staff will remain within auditory range of all clients and conduct room checks every 15 minutes. If a client requires privacy due to changing clothing, showering, or toileting, the staff will maintain within proximal range of the client.

§ 5330.42 During the PRTF's awake hours, the following requirements must be met: (3) A mental health professional shall be present at the PRTF.

As noted in the comment to § 5330.48 (d), requiring non-traditional hours for MPHs will make the PRTFs' recruiting and retention of MPHs more difficult.

Alternate Rule: A mental health professional shall be present at the PRTF for 75% of the waking hours. A mental health professional shall be on call for the remaining 25% of the hours and available to provide telehealth or report to campus to provide support if needed.

§ 5330.47(c) The RN shall have at least 1 year of experience in treating children, youth or young adults with behavioral health needs.

According to The Hospital-Health System Association of Pennsylvania, the nursing shortage in the Commonwealth is among the starkest in the nation due to an aging workforce, burnout, and a shortage of nursing programs.[i] This additional requirement will only further increase the difficulty of hiring nurses in the PRTF setting.

Alternate Rule: The PRTF will provide OMSHAS with records of each nurse's measured competencies regarding an understanding of child development as required by the accrediting bodies. If a nurse's measured competencies reveal a deficit in an understanding of human development in children, youth, or young adults, the PRTF will be required to provide the nurse with additional training.

§ 5330.47(c) Registered nurse. The RN shall have at least 1 year of experience in treating children, youth or young adults with behavioral health needs.

It is already difficult hiring RN's due to PRTFs' inability to offer competitive pay due to the current MA fee structure, and the need for staff RNs on second shifts and weekends. This additional requirement will further challenge the PRTFs' ability to be appropriately staffed. RNs are already trained to work with individuals across the entire human life span. They also work in the context of a milieu and team who also possess this knowledge.

Alternate Rule: The PRTF will provide OMSHAS with records of each nurse's measured competencies regarding an understanding of child development as required by the accrediting bodies. If a nurse's measured competencies reveal a deficit in an understanding of human development in children, youth, or young adults, the PRTF will be required to provide the nurse with additional training.

§ 5330.48 (d) The mental health professional's assigned caseload may not exceed eight children, youth or young adults.

MHPs have been increasingly difficult for PRTFs to recruit due to the highly regulated environment of the PRTFs compared to the flexibility and competitive salaries offered in private practices. The proposed regulations will require MHPs to work non-traditional hours, making the position much more difficult to recruit. This agency already schedules evening and weekend hours for the therapists as best practice. However, due to instances of staff turnover, there are occasionally uncovered shifts. In those circumstances, we would be out of compliance instead of being out of best practice. Turnover in this position is common and the likelihood of occasionally being out of compliance is significant, placing PRTFs at risk of receiving citations for being unable to overcome labor trends beyond their control.

The regulation does not account for the need for clinicians to cover each other when team members are on vacation. The act of picking up clients while a peer was on vacation would put that therapist out of compliance with the proposed rule.

§ 5330.48 (e)(2)(4)(4) Completed a clinical or mental health direct service practicum and have a graduate degree with a least nine credits specific to clinical practice in psychology, sociology, social work, education, counseling or a related field from a college or university accredited by an agency recognized by the United States Department of Education or the Council for Higher Education Accreditation or have an equivalent degree from a foreign college or university that has been evaluated by the Association of International Credential Evaluators, Inc. or the National Association of Credential Evaluation Services. The Department will accept a general equivalency report from the listed evaluator agencies to verify a foreign degree or its equivalency.

The agency requests that consideration be given to internships as well as practicums to fulfill the educational requirements of this rule. Without this revision, the proposed rule unnecessarily limits qualified applicants from consideration.

Alternative Rule: The agency suggests that the term "practicum" be replaced with "clinical field work" to not unnecessarily eliminate qualified applicants from being able to apply.

§ 5330.49. Mental health worker. (c) The mental health worker shall have a high school diploma or the equivalent of a high school diploma and at least 1 year of experience working with children, youth or young adults.

The agency agrees that it would be ideal to only hire candidates with one year of experience, this is not realistic. Under the current funding model, PRTFs are hard-

pressed to compete with wages in the fast food or retail industries. It is already difficult to attract potential mental health workers into a high-stress field with inconvenient work schedules when they can find better-paying jobs with preferable hours. Adding this additional requirement is a further barrier to hiring that will result in increased PRTF rates and diminished bed capacity.

This agency has already adjusted its training of new hires and starts with the assumption all mental health workers have no prior experience with children, youth, or young adults. These new hires already receive training prescribed in the new regulations, including cultural competency, the Sanctuary trauma-informed model, verbal de-escalation, suicide prevention, ethics, professional boundaries, and confidentiality. The agency recently purchased a second online competency-based education platform allowing mental health workers to earn a 16-hour Arts and Science Certificate in youth work.

The agency requests the requirement of a year of experience be removed from the regulation.

§ 5330.50. Additional staff positions (5) The LPN shall have 1 year of experience working with children, youth, or young adults.

This proposed regulation will make it more challenging for PRTFs to staff appropriate nursing rosters. According to the National Center for Health Workforce Analysis, the number of licensed practical nurses declined by over 9% in 2022.[ii] Again, the requirement of the LPNs to have prior experience working with this population will only make hiring more difficult.

LPNs are already trained to work with individuals across the entire human life span. They also work in the context of a milieu and team who also possess this knowledge.

LPNs are already trained to work across the lifespan. They are also working in the context of a milieu and team who possess this knowledge. (Add this to the RN section.)

Alternate Rule: The PRTF will provide OMSHAS with records of each nurse's measured competencies regarding an understanding of child development as required by the accrediting bodies.

§ 5330.51. Initial staff training. (c) Except as required by subsection (d), PRTF staff shall complete at least 30 hours of training in the following areas within 120 days of their date of hire:

and

***Staff* – Individuals employed by a PRTF on a full-time or part-time basis. Staff includes contracted staff, temporary staff, volunteers and interns.**

Applying the staffing requirements to all PRTF volunteers, regardless of how often they directly work with clients, will result in individuals becoming dissuaded from working with clients due to the requirement to complete 30 hours of annual training.

For example, this agency has a volunteer auxiliary that primarily meets to raise money for the residential program. However, a few times a year, the auxiliary plans holiday

parties for our clients. Representatives of the auxiliary attend these parties, but are never alone with the clients, and are never part of the staff ratio.

Alternative Rule: This agency recommends that volunteers who have limited contact with clients (Auxiliary Members, speakers at an assembly, etc.) be exempted from the staff training requirements.

§ 5330.52. Annual staff training. (b) PRTF staff shall have at least 30 hours of annual training in the areas specified in §5330.51(c) (relating to initial staff training).

Currently PRTF staff who are not working with clients are not regulated by any annual training requirements in the 3800s. PRTFs are responsible for establishing their own training standards based on their policies and any professional standard accompanying each staff role. However, 5330s prescribes 30 hours of annual training, with many of the topics having no relevance to the staff's role. For example, billing agents do not need to be trained in the use of manual restraints, verbal de-escalation, mental health diagnoses, or principles of child development.

Alternate Rule: PRTF workers not working with clients must have annual training on fire safety, blood-borne pathogens, first aid, CPR, the agency's trauma-informed model, harassment training, and cultural competency.

§ 5330.77. First aid supplies. (a) A PRTF shall have a first aid kit available to PRTF staff on every floor of the PRTF.

Requiring first aid kits to contain opioid reversal medication and be located on every floor of a PRTF is excessive. This will create more undue costs for providers and require more monitoring.

Alternative Rule: A PRTF shall have a first aid kit available to PRTF staff in central locations in each building.

§ 5330.112. Initial medical assessment. (e) If a physician did not complete the initial medical assessment, a physician shall review and sign the initial medical assessment within 3 days from the date the initial medical assessment was completed.

This proposed regulation will have unintended consequences regarding the PRTFs capacity to admit clients. For example, if a client were admitted on a Thursday or a Friday and a physician was not present on either of those days, a physician's signature would not be able to be secure over the weekend, playing the PRTF in a state of noncompliance.

PRTFs will be required to increase the number of contracted hours with PCPs, an expense that is not accounted for in OMSHAS' estimated fiscal impact statements. PRTFs are dependent on the available of contracted PCPs who are willing to accept MA rates and will find it difficult to find enough doctor's time to meet the demands of this regulation, which will result in needless delays in admissions.

Alternate Rule: If a physician did not complete the initial medical assessment, a physician shall review and sign the initial medical assessment within 15 days from the date the initial medical assessment was completed.

§ 5330.118. Use of drugs, alcohol, tobacco and e-cigarettes. (c) Use or possession of drugs, alcohol, tobacco and e-cigarettes products by a PRTF staff is prohibited

It is reasonable that PRTF staff be allowed to take over the counter and prescription drugs while working in the PRTF.

Alterative Rule: (c) Use or possession of illegal drugs, alcohol, tobacco and e-cigarettes products by a PRTF staff. Over the counter or prescription medication must be secured in a locked container during the shift.

§ 5330.145. Treatment services. (c) The following must be provided in accordance with the child's, youth's or young adult's treatment objectives:

(1) Individual therapy with the child's, youth's or young adult's treatment team leader must be provided for at least 1 hour each month.

This regulation is problematic for two reasons. Since the 1990s, there has been a steady decline in the amount of psychotherapy provided by psychiatrists. The percentage of psychiatric visits which involve psychotherapy dropped to 21.6% of patient visits between 1996 and 2016.[iii] There is no data to suggest a reversal in this trend. This data suggests PRTFs will have difficulty hiring psychiatrists proficient in providing psychotherapy.

Against this backdrop, there is a well-documented shortage of psychiatrists in Pennsylvania. According to the American Academy of Child and Adolescent Psychiatrists, Pennsylvania has 18 child and adolescent psychiatrists per 100,000 children, placing the state in the "High Shortage" category (18-46%). 45% of Pennsylvania counties do not have a single psychiatrist with a specialty in children and adolescents. The average child and adolescent psychiatrist is age 54 which indicates that the workforce may continue to contract due to retirement. A 2018 article published in the National Library of Medicine stated that it was unclear if the current psychiatric shortage would be resolved by 2050.[iv] It should be noted that those projections were made before the pandemic and the subsequent increased demands for behavioral health and substance services. The Kaiser Foundation estimated that as of April 1, 2024, Pennsylvania would require an additional 59 psychiatrists to remove the 118 Health Professional Shortage Areas that have been identified in the Commonwealth.

Against this backdrop, OMHSAS proposes that each PRTF client have one hour of individual therapy each month with the treatment team leader. To comply with this regulation, Sarah Reed Children's Center would have to employ a full-time treatment team leader at an estimated cost of $325,000 annually (not including benefits), plus recruiting incentives to maintain regulatory compliance at its current average census of 30 clients. The agency would have to hire two more treatment team leaders to return to its licensed capacity of 57 beds.

This proposed regulation places the impossible burden of the commonwealth's PRTFs having to recruit and hire a high volume of psychiatrists against the setting of the state and national psychiatric shortage. This will inevitably result in the closure of PRTFs and a further unwelcome reduction in the number of beds.

Requiring the treatment team leader and the mental health professional to provide therapy for the client is ethically and clinically problematic. The arrangement creates triangulated clinical relationships and is especially inappropriate when the treatment team leader provides clinical supervision to the mental health professional.

§ 5330.145. Treatment services. (c) The following must be provided in accordance with the child's, youth's or young adult's treatment objectives:

(1) Individual therapy with the child's, youth's or young adult's treatment team leader must be provided for at least 1 hour each month.

(2) Individual therapy with the child's, youth's or young adult's mental health professional must be provided for at least 2 hours each week.

(3) Group therapy must be provided for at least 3 hours each week. PRTF staff that meet the qualifications of a mental health professional, clinical director or treatment team leader shall facilitate group therapy.

(4) Family therapy as follows:

(iii) Family therapy must be provided for at least 1 hour each week.

(5) Psychoeducation group therapy must be provided at least 3 hours each week.

The agency points out that the Department has provided no evidence-based research to support these arbitrary standards for treatment. Furthermore, these standards violate the Pennsylvania-mandated CASSP Principle of "Child Centered Treatment" which states that services are planned to meet the individual needs of the child, rather than to fit the child into an existing service.

This lack of individualization creates the potential for children, youth, and young adults to be over-saturated with therapy. When individuals become therapy fatigued due to the constant focus on their mental health issues and past trauma, they can become overwhelmed and exhausted. This results in decreased motivation and engagement in therapy sessions, which could result in longer placements in the PRTF.

In some cases, clients become dependent on therapy and then struggle to cope with their issues independently, which can hinder their ability to develop self-reliance and resilience leading them to be ill-prepared for discharge.

At the time of admission, parents/guardians are sometimes unable to tolerate family therapy and need time to process their own frustrations before engaging.

These standards do not account for a constellation of factors including client's age, diagnoses, developmental delay, cognitive level, or family system.

Alternative Rule: The treatment team will determine the frequency of the child's treatment based on the frequency, intensity, and duration of the child's problematic behavior.

§5330.141. Treatment planning requirements. (d) PRTF staff shall maintain a communication log for each child, youth or young adult that includes daily notes about the child's, youth's or young adult's behaviors and observations about the child, youth or young adult that can be used by the treatment team in the treatment planning process.

This proposed rule is asking for a duplication of the electronic medical record. Each day floor staff enter narratives summarizing each client's behavior, three times a day into the EHR. In addition to the narratives, they use the D.A.P. (Description, Assessment, Plan) format to describe the therapeutic groups that were led and each client's response to them. These daily progress notes currently provide data used by the treatment planning team. Staff use alerts with in the electronic medical record to notify clinicians and coworkers about significant behaviors which occur on the shift.

This rule calls for a duplication of service entry which already occurs daily and would create an administrative burden that would detract from the client care.

This rule should be omitted from the final regulation.

§ 5330.142. Treatment plan.(1) A multi-disciplinary assessment and screening must be completed within 48 hours of a child's, youth's or young adult's admission to the PRTF.

Clients often undergo significant emotional adjustments during the process of being admitted into a PRTF. Requiring them to submit to multiple screenings within a twenty-four-hour window is excessive and at times not trauma informed.

The agency also seeks clarification regarding the phrase "a multi-disciplinary assessment and screening." Discussions with providers reveal multiple readings of this phrase. Does it refer to the psychosocial assessment or to multiple treatment team members each providing a unique assessment within their discipline? Either way, the forty-eight-hour window is too short.

Alternative rule: (1) A multi-disciplinary assessment and screening must be completed within 10 days of a child's, youth's or young adult's admission to the PRTF.

§ 5330.147. Discharge.

The proposed regulations do not account for discharges that occur against medical advice. The agency requests that this contingency be addressed to prevent PRTFs being held accountable for situations over which they have no control.

5330.151. Transportation.

(b) A driver of a vehicle may not be counted towards the supervision ratio requirements specified in subsection (d).

(c) A driver of a vehicle and at least one PRTF staff person shall be present in the vehicle when a child, youth or young adult is being transported.

(d) There shall be at least one PRTF staff person present for every three children, youth or young adults being transported.

Most PRTFs are currently not operating at their licensed capacity due to chronic staffing shortages. The proposed transportation ratios will make it difficult for the agency to assist in the transportation of clients on family visits, especially around the holidays when client visits increase. Providing transportation to court hearings and required health care appointments could become increasingly difficult.

It should be noted that meeting the transportation staffing ratios will only increase the difficulty of meeting the on-campus staffing ratios, which is proposed to change to 1:6.

5330.1469(d) provides clients with the right to participate in educational extra-curricular activities, personal enrichment, and vocation events that are reasonably available. However, the proposed transportation ratios will diminish PRTFs' capacity to help clients participate in these activities. The cost of creating alternatives experiences on campus would only create additional expenses for the PRTFs.

(e) A manual restraint may not be utilized on a child, youth or young adult during transport.

The agency seeks clearer language. Does transport mean “while the vehicle is in motion” or the entire trip including stops and time spent at the destination?

Alternate Rule: A manual restraint may not be utilized on a child, youth or young adult while a vehicle is in motion.

§ 5330.166(c). Medication refusal. A PRTF shall inform the child's, youth's or young adult’s treatment team leader of the refusal to take prescription medication as soon as possible, but no later than 1 hour after the refusal.

This time window is excessively restrictive as it does not account for the potential of the nursing staff being pulled away to observe a restraint or other crisis.

Alternative Rule: A PRTF shall inform the child's, youth's or young adult’s treatment team leader of the refusal to take prescription medication as soon as possible, but no later than 2 hours after the refusal.

§ 5330.181.(e) Use of Manual Restraints. A PRTF shall develop a written policy and procedure for the use of manual restraints that include the following (3): A performance improvement process that must be reviewed every 30 days to monitor and reduce the use of manual restraints.

This PRTF has multiple systems in place for reviewing restraints including the use of video review to coach/debrief staff and the weekly review of clinical review of clients with a high number of restraints the prior week. A monthly review of these established processes is unnecessarily frequent and could result in superficial reviews of our processes.

§ 5330.182 (i) An order for a manual restraint and the application of a manual restraint may not exceed 30 minutes.

This proposed rule is far more stringent than what is required by the Federal regulations (see 42 CFR 483(e)(2)), which permits a manual restraint for no more than 4 hours if the individual being restraint is between 18-21 years old; no more than 2 hours of the individual being restrained is 9-18 years old; and for no more than 1 hour if the individual is under the age of 9.

To minimize the excessive use of restraints and to minimize the trauma that can arise because of the use of a restraint, this agency already places a 1-hour limitation on

restraints for clients of any age and requires that an attending psychiatrist be contacted when the restraint exceeds a half hour. *--Acknowledge traumatizing to staff and clients,*

Limiting restrictive procedures to a half-hour length has the potential to create an unnecessary safety risk for both staff and the client as it is possible that clients may need to be released from the restraint before they have physically de-escalated. It would also necessitate the creation of a second restraint form and the required additional reporting and debriefing requirements.

Alternate Rule: § 5330.182 (i) An order for a manual restraint and the application of a manual restraint may not exceed one hour. When the restraint exceeds 30 minutes, the attending psychiatrist must be updated.

§ 5330.184. Restrictive procedure plan (a) A restrictive procedure plan must be written within 24 hours of a child's, youth's or young adult's admission to a PRTF and prior to the use of a manual restraint.

Requiring restrictive procedure plans to be written at the time of admission will result in in lack of individualization of the plan as the facility will have no time to observe the client.

Agency Recommendation: That 3800.24 Unanticipated Use be continued in the 5300 regulations, which calls for the creation of a restrictive procedure plan after any type of restrictive procedure is used four times for the same child in any 3-month period.

§ 5330.185 (a) A PRTF shall have at least two PRTF staff present during the application of a manual restraint.

This agency agrees that having two staff present during the application of a restraint is ideal. However, there are circumstances where this is not possible. For example, if a client who has expressed suicidal intention attempts to elope, a staff person would pursue the client, and if necessary, restrain the client for their safety. At the start of the restraint, it is possible that a second staff person may not be available. Other circumstances include when a staff person transitions the client from one building to another. It is highly unlikely that a second staff person would be physically present to assist with restraint in those circumstances. However, to ensure client staff, our agency has video surveillance cameras monitoring the campus grounds as well as inside the buildings.

This agency is set in a well trafficked residential neighborhood with two major highways nearby. We provide services to young and impulsive clients capable of endangering themselves by running in front of passing cars.

Our staff are trained in the state-approved Safe Crisis Management program which includes training in applying single-person manual restraints safely.

This proposed rule would result in PRTFs exercising greater caution when considering admitting clients with a history of acute crisis behavior.

The agency suggests that this rule be eliminated.

§ (i) Within 30 minutes of initiation of a manual restraint or immediately after a manual restraint is removed, a treatment team leader, physician, APP or RN, who is certified in the use of manual restraints, shall conduct a face-to-face assessment…

This proposed rule halves the Federal standard of a 1-hour window for the face-to-face assessment to occur. It is likely that clients may not be sufficiently deescalated after the restraint to cooperate with the face-to-face assessment. This standard could be impossible to meet if multiple restraints occur simultaneously on campus. Reducing this window will make it difficult for nurses to meet this standard if multiple manual restraints are being administered on campus simultaneously. It will also make it more challenging for on-call registered nurses to respond on time when called in to complete a face-to-face evaluation, especially in rural areas or in the event of inclement weather.

The agency requests that the time window for the face-to-face evaluation not be changed from the one-hour time frame prescribed in CFR §483.358.

§ 5330.185 (k) A PRTF shall notify the child's, youth's or young adult's parent, legal guardian or caregiver of the manual restraint within 1 hour after the manual restraint has ended.

At times this proposed rule will create an unrealistic burden on the PRTF staff as on occasion multiple clients can be dysregulated at once. The CFR states that the parent /legal guardian contact happens "as soon as possible" but not place a specific period in which the contact must take place. Our agency policy requires the contact to occur within the 24-hour window. The proposed 1-hour window for parent contact is excessively short by comparison and creates unnecessary potential for regulatory non-compliance on the part of the PRTFs. These regulations do not account for the staff sometimes having to attend to multiple crises on campus and the subsequent administrative tasks that follow. The rules does not account for barriers parents encounter such as location, work, and responsibilities with other family members.

Alternate Rule: A PRTF shall notify the child's, youth's or young adult's parent, legal guardian or caregiver of the manual restraint as soon as possible, but not longer than within 24 hours after the manual restraint has ended.

§ 5330.187 (b)(10) Written statements from PRTF staff describing the events prior to, during and following the manual restraint from each PRTF staff person who was directly involved or who observed the manual restraint.

Federal regulations (§483.358(h)(4) require the documentation of the emergency safe situation that necessitated the restraint. The agency satisfies those requirements by having the restraint team leader document the narrative in the restraint form that includes the client's antecedent behaviors, using the Behavior, Intervention, Response (B.I.R.) format.

It should be noted that Federal regulations already require the presence of an observer during a restraint and that many PRTFs, including this agency, also utilize recorded video surveillance.

Requiring each participant in the restraint to submit their own written statements is an excessive administrative burden that exceeds Federal regulation. This agency notes that if there was an injury or a complaint to arise from the result of a restraint, the Residential Director will require statements from all involved staff members as part of their investigation.

Alternate Rule: § 5330.187 (b)(10) In the event that the restraint results in a client injury, written statements from PRTF staff describing the events prior to, during and following the manual restraint from each PRTF staff person who was directly involved or who observed the manual restraint.

§ 5330.188 (b) Within 24 hours after the use of a manual restraint, a face-to-face discussion with the child, youth or young adult must occur and include the following: (2) Representatives from the child's, youth's or young adult's treatment team.

Requiring representatives of the treatment team, in addition to the PRTF staff involved in the restraint creates a scheduling and administrative burden and reduces the likelihood that the debrief can occur within the CFR-mandated 24-hour window for the debrief to occur. Representatives of the treatment team after frequently not scheduled to work in the evenings or weekends. Moreover, there is no corresponding Federal regulation.

Alternate Rule: § 5330.188 (b) Within 24 hours after the use of a manual restraint, a face-to-face discussion with the child, youth or young adult must occur and include the following: (2) Representatives from the child's, youth's or young adult's treatment team, if available.

§ 5330.188 (b) Within 24 hours after the use of a manual restraint, a face-to-face discussion with the child, youth or young adult must occur and include the following: (3) The child's, youth's or young adult's parent, legal guardian or caregiver, if available.

This proposed rule exceeds Federal regulations regarding child debriefing following a restraint. A client's Mental Health Professional already has the discretion of discussing the events leading up to a manual restraint in family therapy with the client and parent or guardian. Requiring parent or guardian participation in each child debrief, when possible, combined with the requirement of having a representative of the client's treatment team in the debrief, will necessarily make the increasingly difficult to schedule these debriefs within the required 24-hour window.

The regulation does not account for the fact that state workers assigned to adjudicated youth will not be available during the evenings and weekends to participate in the debrief.

The agency recommends that this rule be omitted.

§ 5330.188(d) Within 24 hours after the use of a manual restraint, the PRTF staff involved in the manual restraint, supervisory and administrative staff, shall conduct a debriefing that includes, at a minimum, a review and discussion of the following:

This proposed rule requires the presence of both a mental health worker supervisor and a PRTF administrator in the staff debrief. We ask for clarification as to who is administrative staff are as defined by the regulations. Our concern is that, depending on their definition, administrative staff may not be available to participate in the debriefs due to their schedules.

§ 5330.221. Quality assurance requirements.

The §5330 regulations do not have quality assurance requirements. This agency already has a quality assurance program which already accomplishes several of the requirements of the proposed annual report including a restraint reduction analysis, program review, and staff, client, and parent satisfaction surveys. However, meeting 5330.221(a)(2)(iii) "Assessment of delivered service outcomes and if treatment plan goals have been completed" would require additional staffing hours from a qualified staff person, at least a mental health professional, adding additional annual expenses.

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[i] Fact Sheet: Pennsylvania's Nurses Are More Than a Number - Resource Center (haponline.org)

[ii] State of the U.S. Health Care Workforce, 2023 (hrsa.gov)

[iii] Tadmon D, Olfson M. Trends in outpatient psychotherapy provision by U.S. psychiatrists: 1996–2016. *Am J Psychiatry.* 2022;179(2):110-121. Accessed 10/20/2024.

[iv] https://pubmed.ncbi.nlm.nih.gov/29540118/ Accessed 09/05/24 at 9:44 AM.